



Managed Care: Contract Oversight and Monitoring

**Charles Smith – Executive
Commissioner**

**Stephanie Muth –State Medicaid
Director**

**Andy Vasquez – Deputy Associate
Commissioner, Quality & Program
Improvement**



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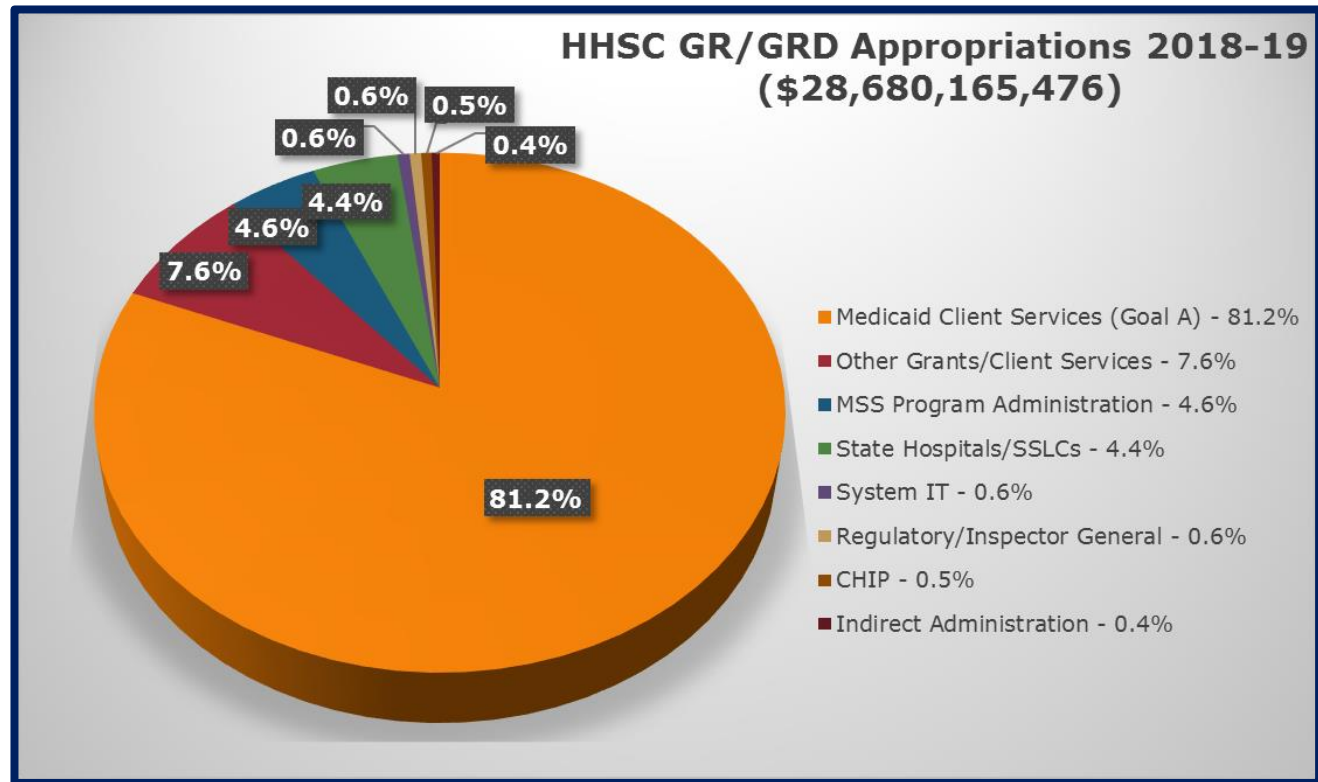


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HHS budget overview

Majority allocated to Medicaid client services

81.2% of the overall budget



- Other Grants/Client Services include TANF, Women's Health, MHBG, ECI, etc.
- MSS Program Admin includes salary, travel, and contracts (Eligibility staff, TIERS, TMHP, etc.)
- State Supported Living Centers appropriations include Medicaid funding.
- Indirect Administration includes PCS, FSD, GR/Comms, Legal, Internal Audit, Regional Support, etc.

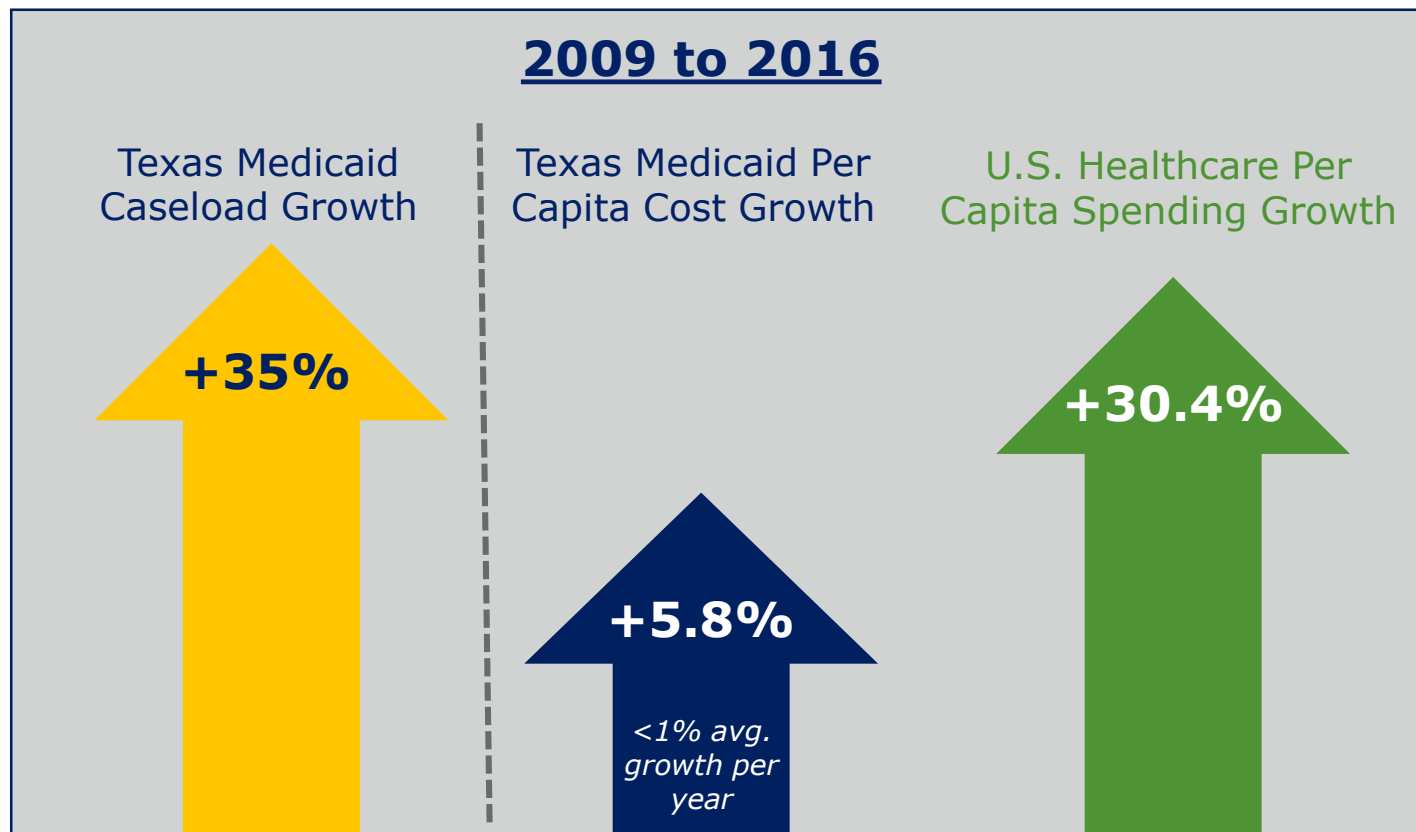


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Medicaid cost growth

Caseload is the primary driver of cost

Even with caseload increases, Texas Medicaid cost per person cost growth is substantially lower than the national trend.





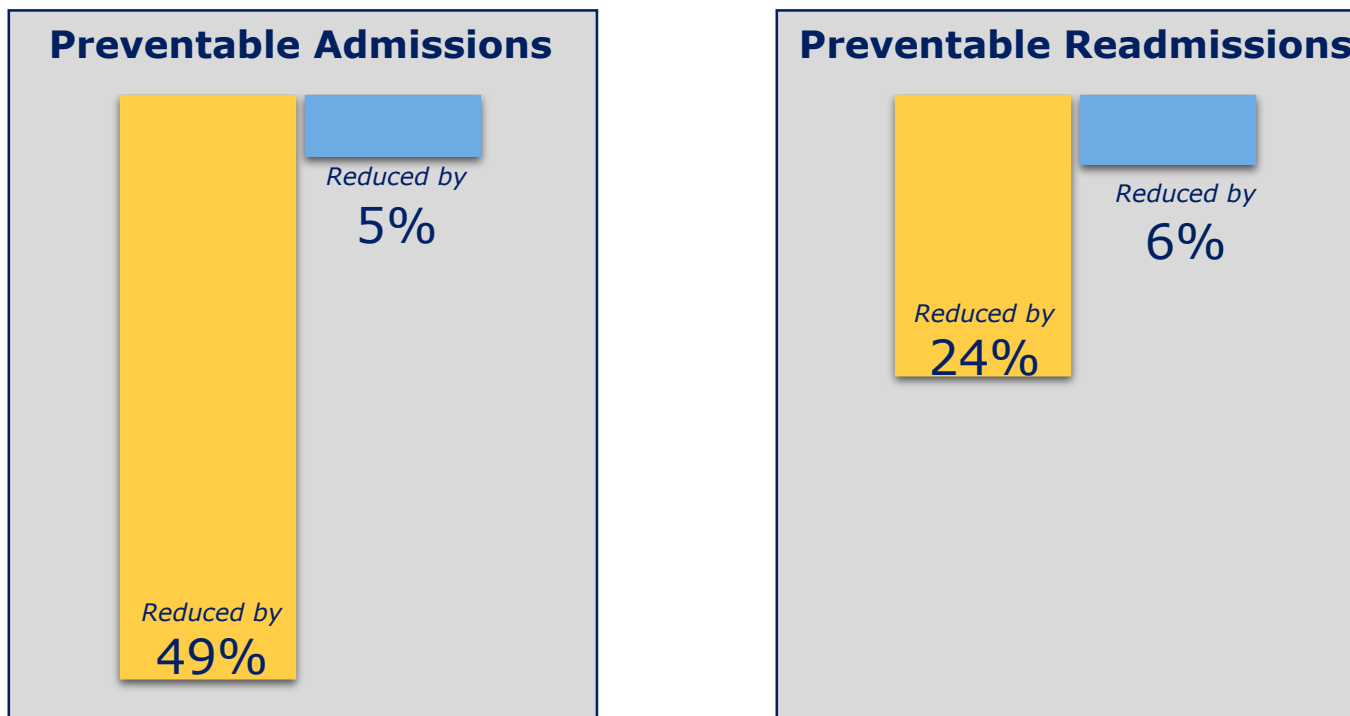
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Positive outcome trends

Reduced potentially preventable events

Improved access to care, ambulatory care coordination, and quality of care may reduce hospital admissions and readmissions.

CY 2013 - 2016



■ STAR ■ STAR+PLUS

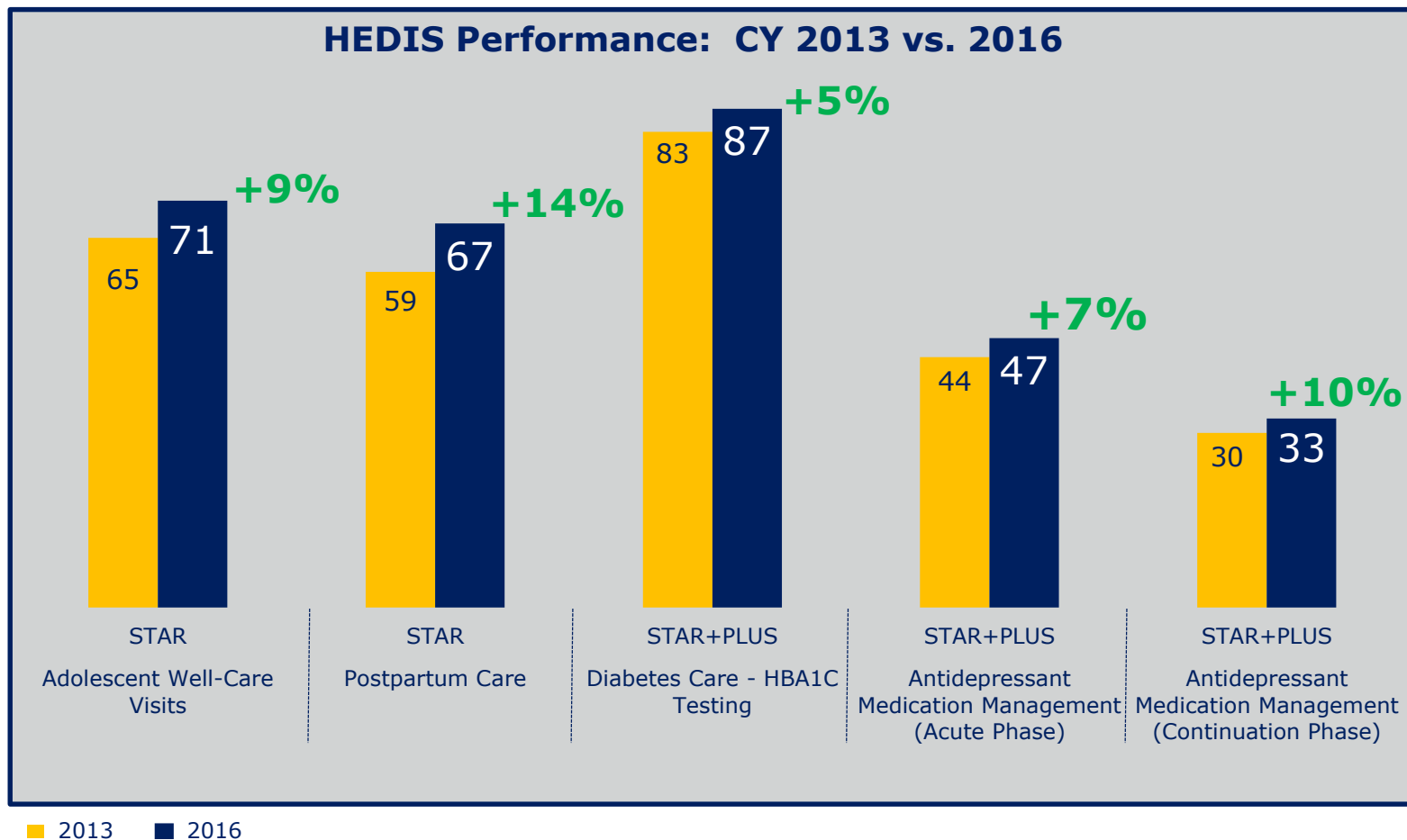


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Positive outcome trends

HEDIS measures for Texas managed care

Measures demonstrate improvement in the effectiveness of or access to care.



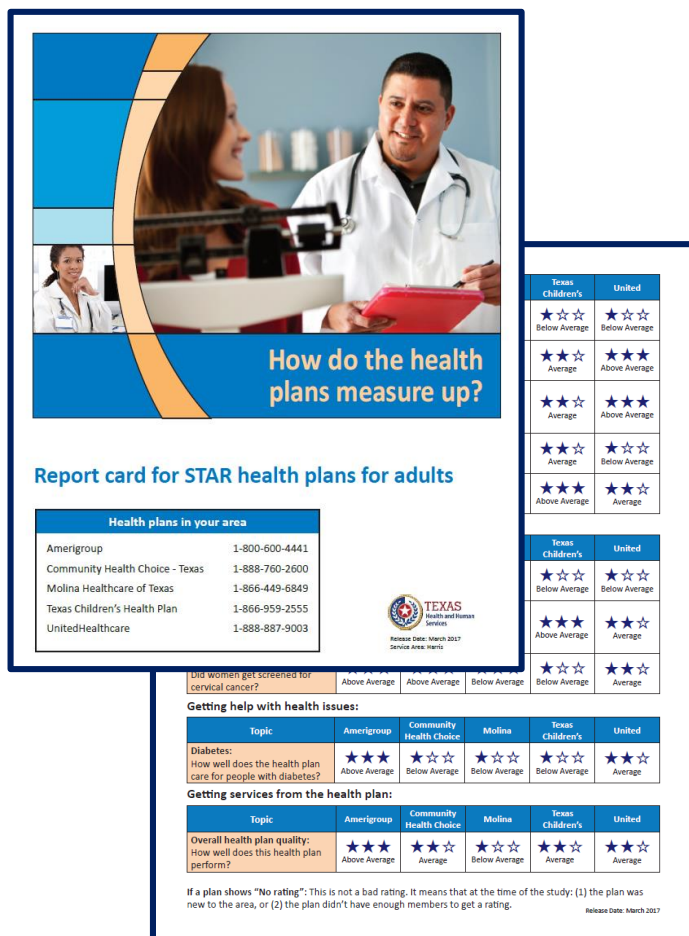


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Health plan report cards

Quality measures that matter to members

Input **by** members **for** members on plan satisfaction



- Four key areas graded:
 - Getting help from the doctors and plan
 - Getting check-ups and tests
 - Getting help with health issues
 - Overall plan quality
- Ratings by plan based on member surveys and medical bill analysis
- Transparency for members when selecting or changing plans



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Incentivizing value-based care Based on the Triple Aim

Defined by three factors: experience of care,
health of population, and per capita cost.

Pay for Quality (P4Q)

Medical measures:

- Prevention
- Chronic disease management (including behavioral health)
- Maternal and infant health

Dental measures:

- Annual oral evaluations
- Primary prevention against dental caries (cavities)

% capitation at risk

Measurement began January
2018

Alternative Payment Model (APM)

Contracts require a minimum %
of provider payments linked to
quality based APMs

Annual % increases over four
years

*Year 1 (CY 2018) minimum APM
ratios:*

- Overall: $\geq 25\%$
- Risk-Based: $\geq 10\%$

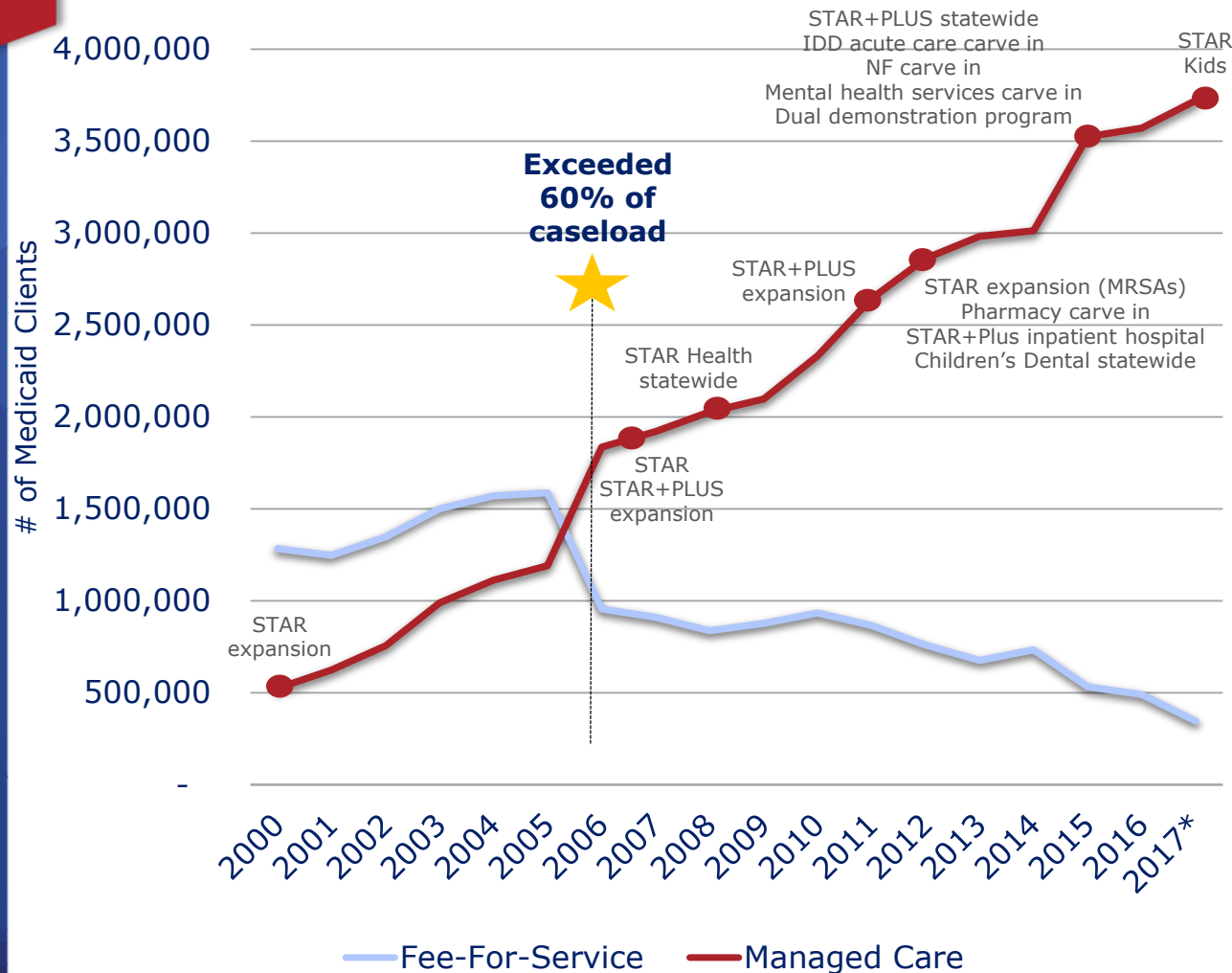
Measurement began January
2018



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An evolving landscape

Rapid growth of managed care model



**92% of
caseload**

**+1.2MM
in 10 years**

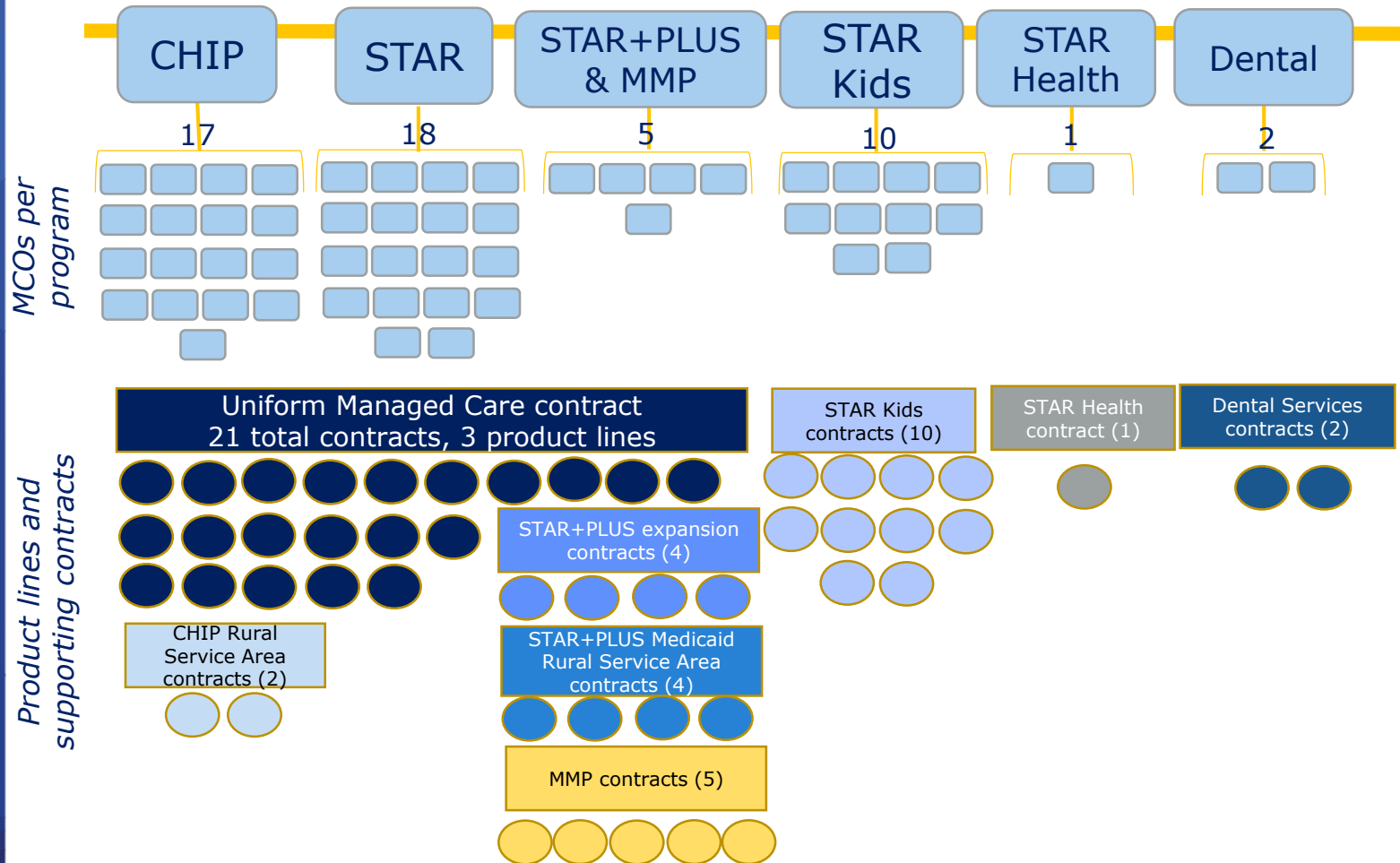


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An evolving infrastructure

Supporting managed care

Managed Care Programs





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Contract lifecycle approach

Multiple points being leveraged for oversight

Strength in oversight comes from an integrated horizontal and vertical approach within the organization.

Pre-contract stage

- ✓ Ongoing leadership engagement in the Request for Proposal (RFP) process
- ✓ Comprehensive contract development and structuring
- ✓ Robust readiness reviews and transition process

Management and oversight of the contract

- ✓ Policy and Program Requirements
- ✓ Encounter Data
- ✓ Performance on Quality Metrics and Initiatives
- ✓ Operational Compliance
- ✓ Financial Compliance
- ✓ Utilization Reviews

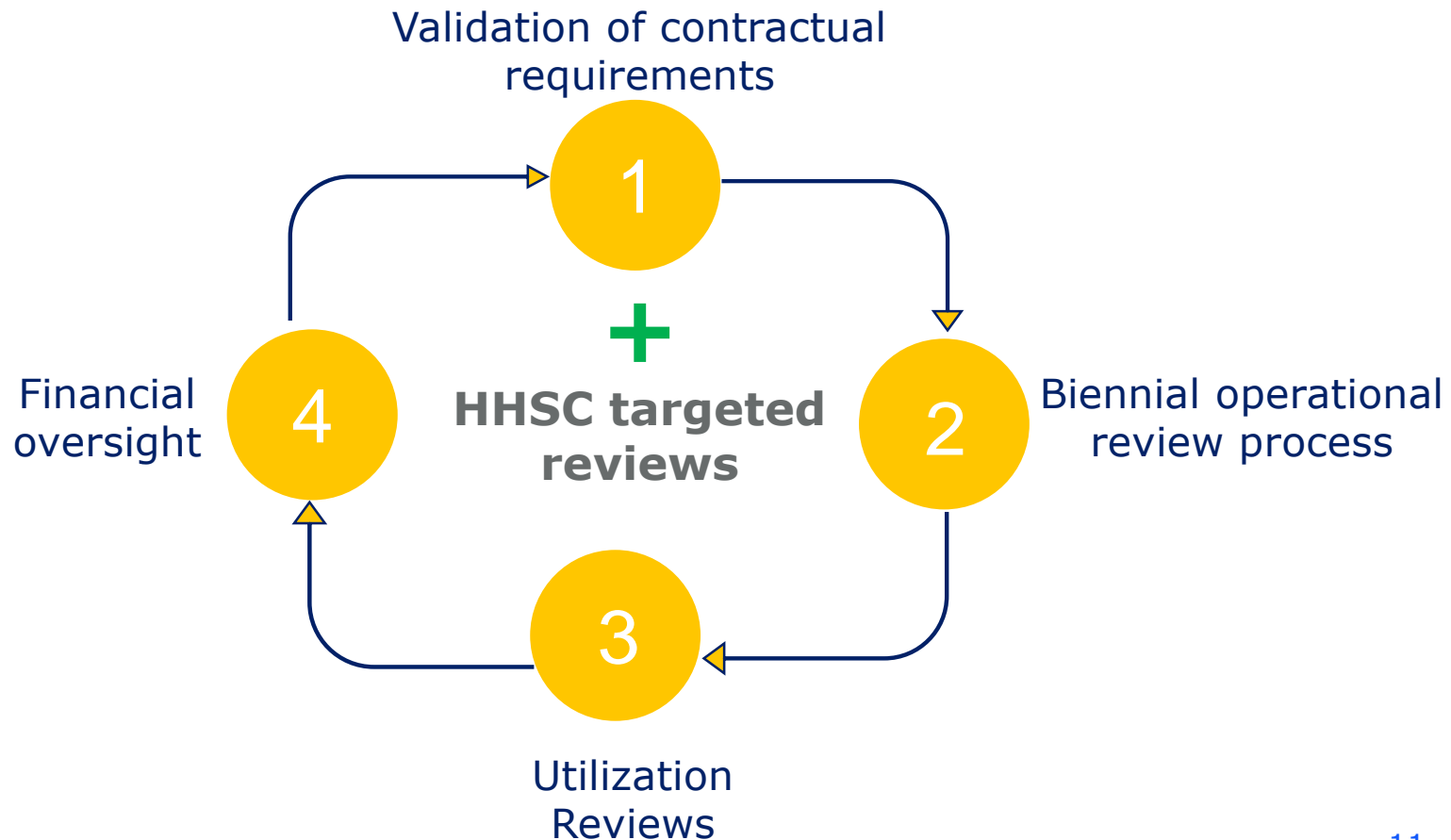


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Contract oversight tools

Span a multitude of areas

Administered by various expertise across the organization.





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Strength in oversight

Starts with contract formation

Example: Financial Oversight



Non-compliance discoveries enforced as established in the contract, including liquidated damages or recovery of the Experience Rebate (i.e. recovery of "excess profit").

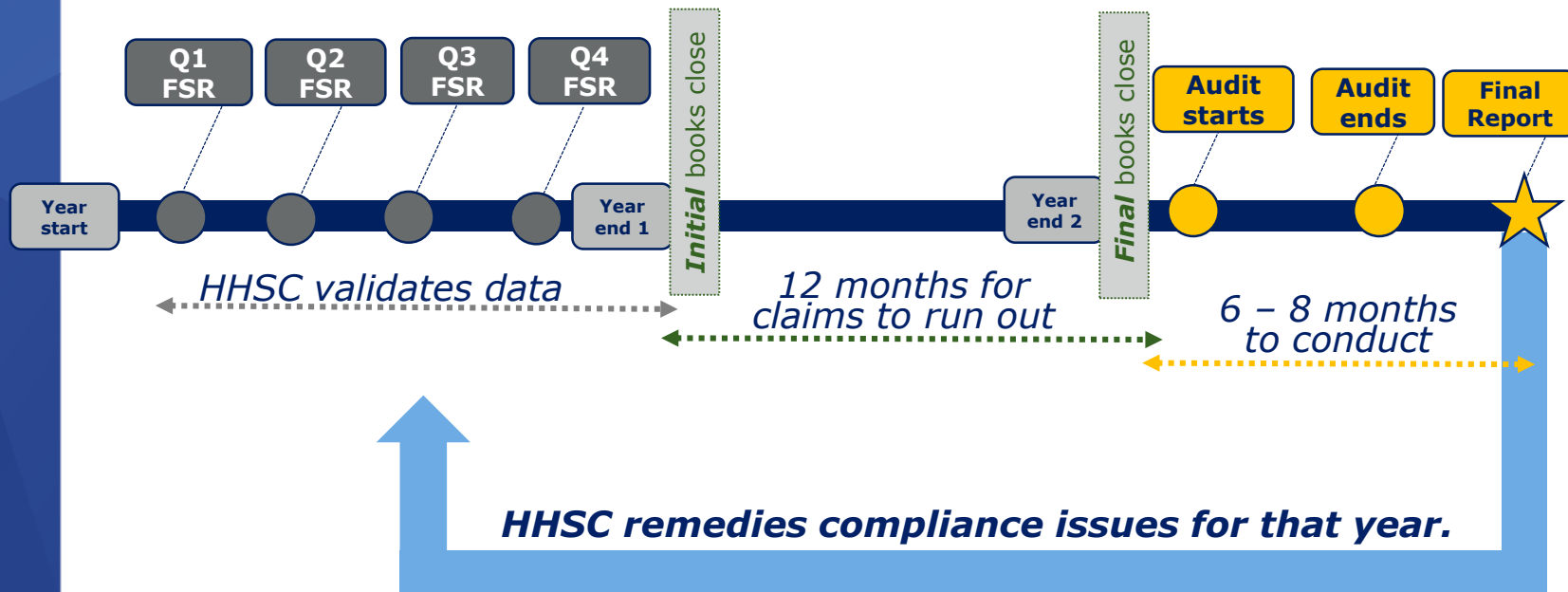


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Financial oversight

Timeline for managing compliance

An 18-20 month audit process post-year end.



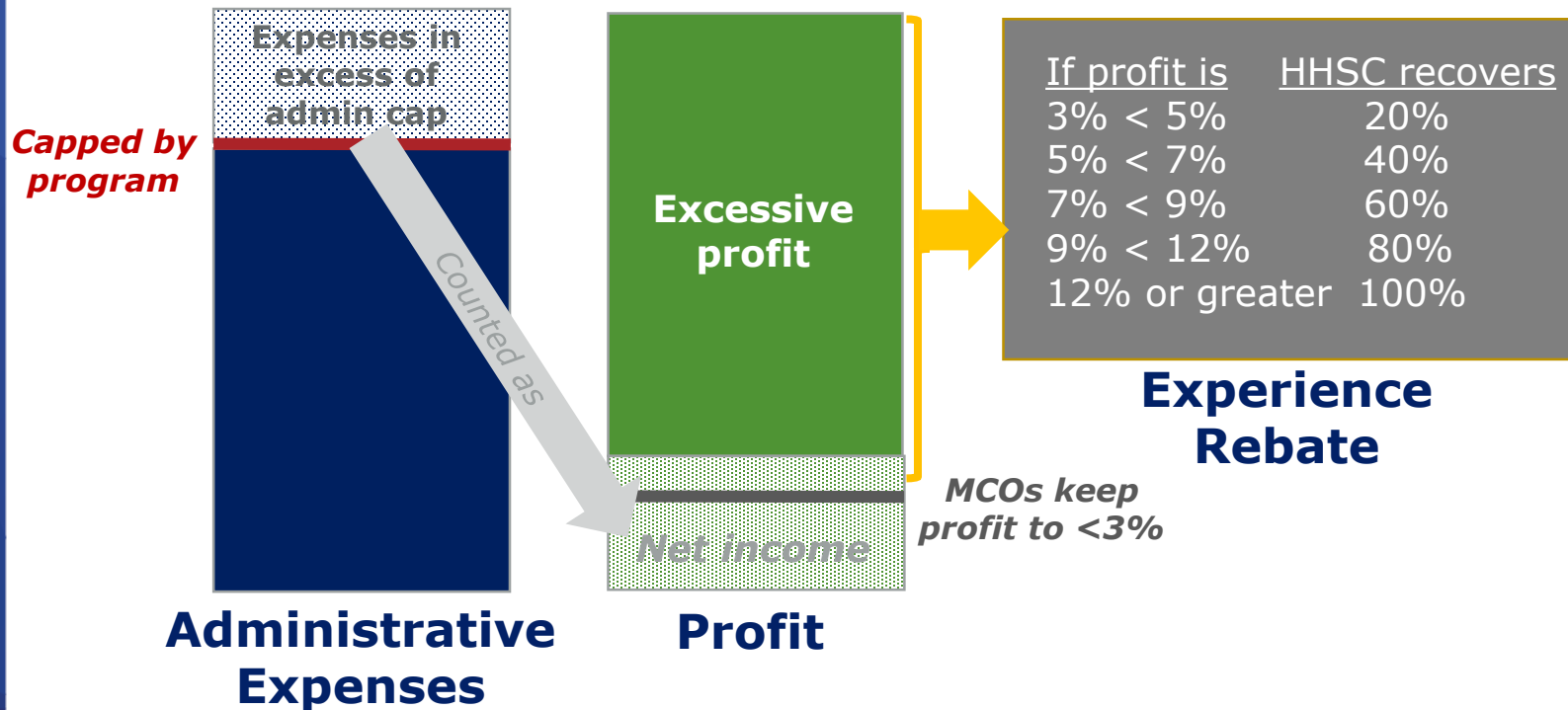


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Contract financial structure

Safeguards to ensure FISCAL responsibility

Major components are caps on administrative expenses, conversions to income, and rebates on excessive profit.





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Operations oversight tools

HHSC and external auditors

Like financial oversight, operations has multiple monitoring perspectives.

HHSC onsite biennial
operational reviews

Critical indicator focus

Claims
Processing

Encounter
Data

Provider
Relations

Prior
Authorization
Process

Complaints/
Appeals

Utilization
Management

Call Center
Functioning

Website
Critical
Elements

+ Additional modules
under development

3rd party biennial performance audits
(or more frequently as determined by risk)

Two areas of focus

MCO self-
reported data

Operational
processes

Targeted area(s) may vary.
Examples include:

- MCO Hotlines
- Complaints and Appeals
- Claims processing
- Subcontractor monitoring (including PBMs)

Can inform the focus of the 3rd party audit or
the need for an incremental one.

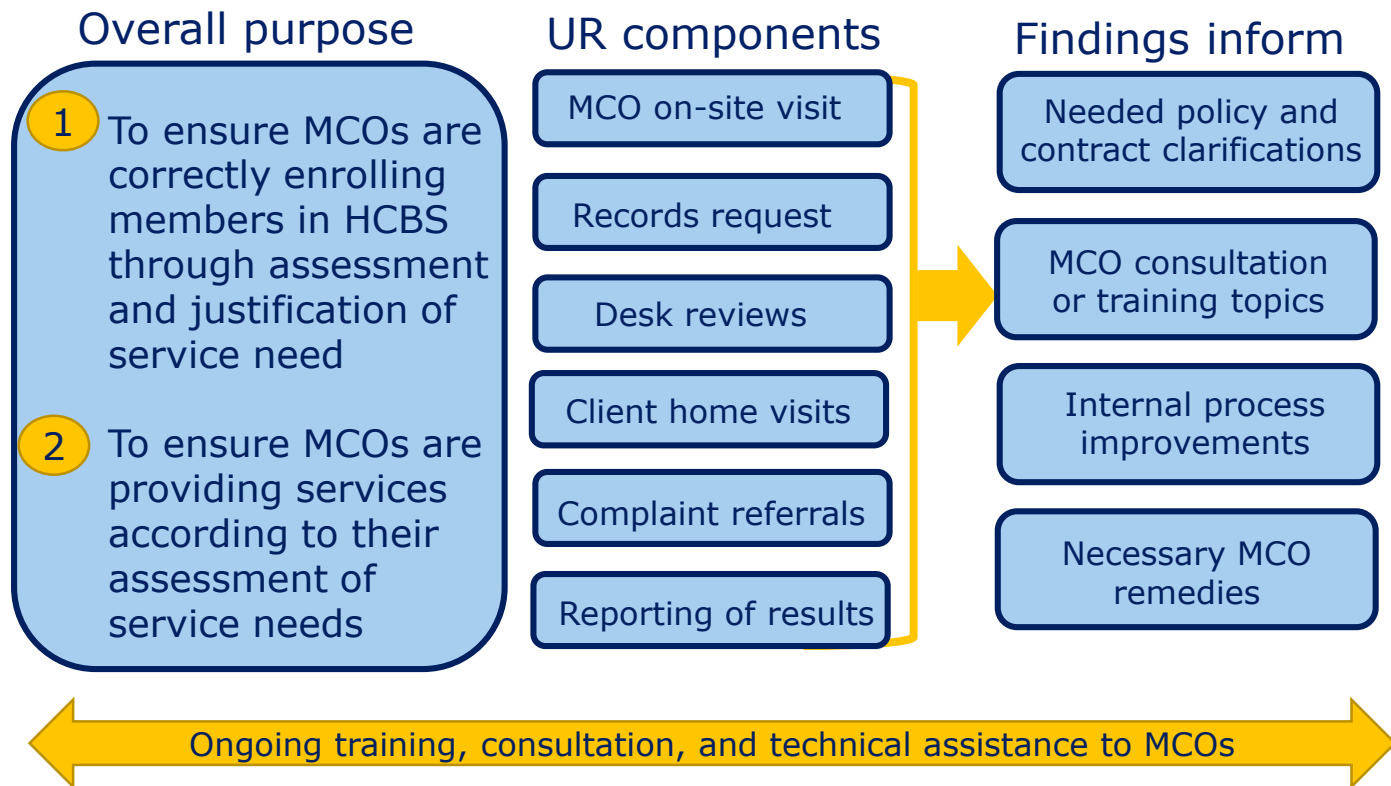


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Services oversight tool

Utilization Reviews

Utilization Reviews (UR) are conducted by nurses and overseen by the Office of the Medical Director.





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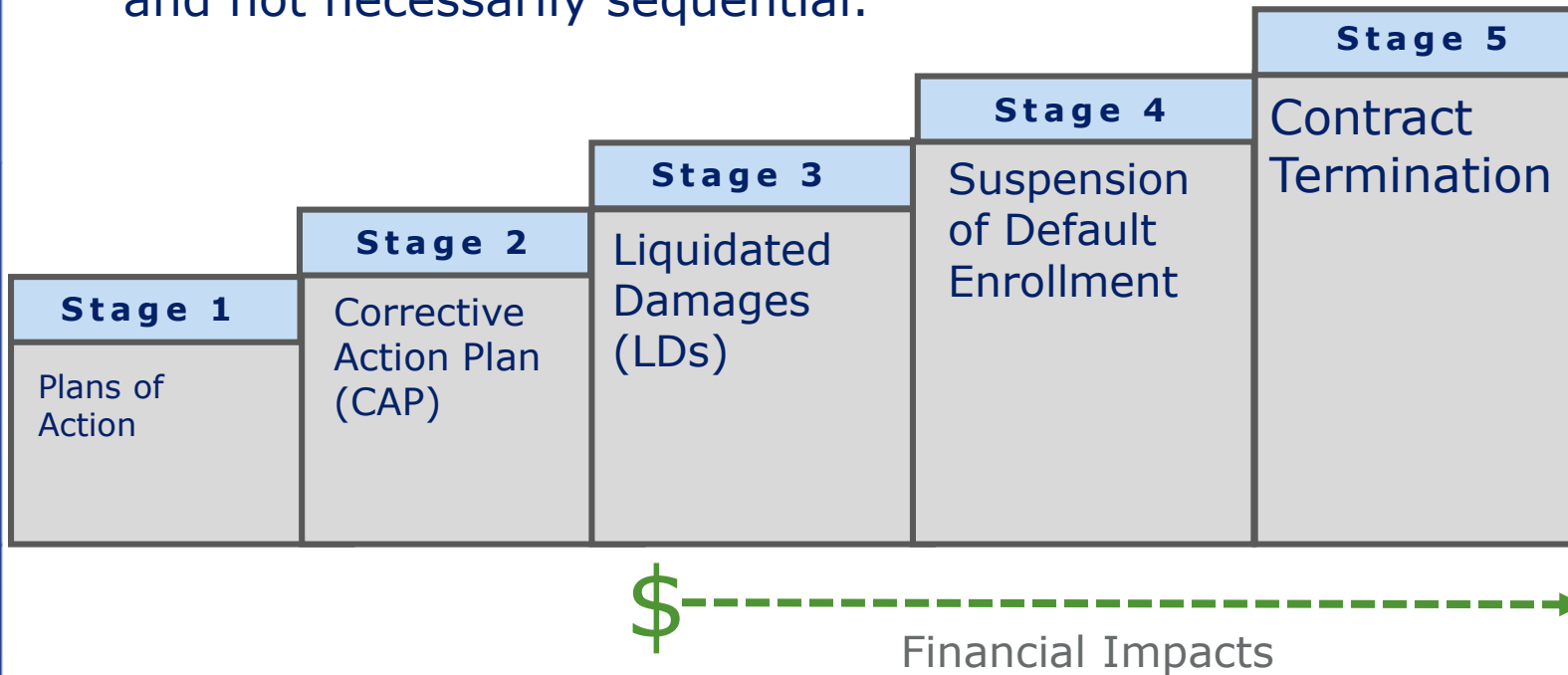
Addressing non-compliance

Graduated remedy process

Multiple stages to address non-compliance discovered via oversight and monitoring.

Increased levels of impact for MCOs.

Remedy issued is contingent on type of non-compliance and not necessarily sequential.



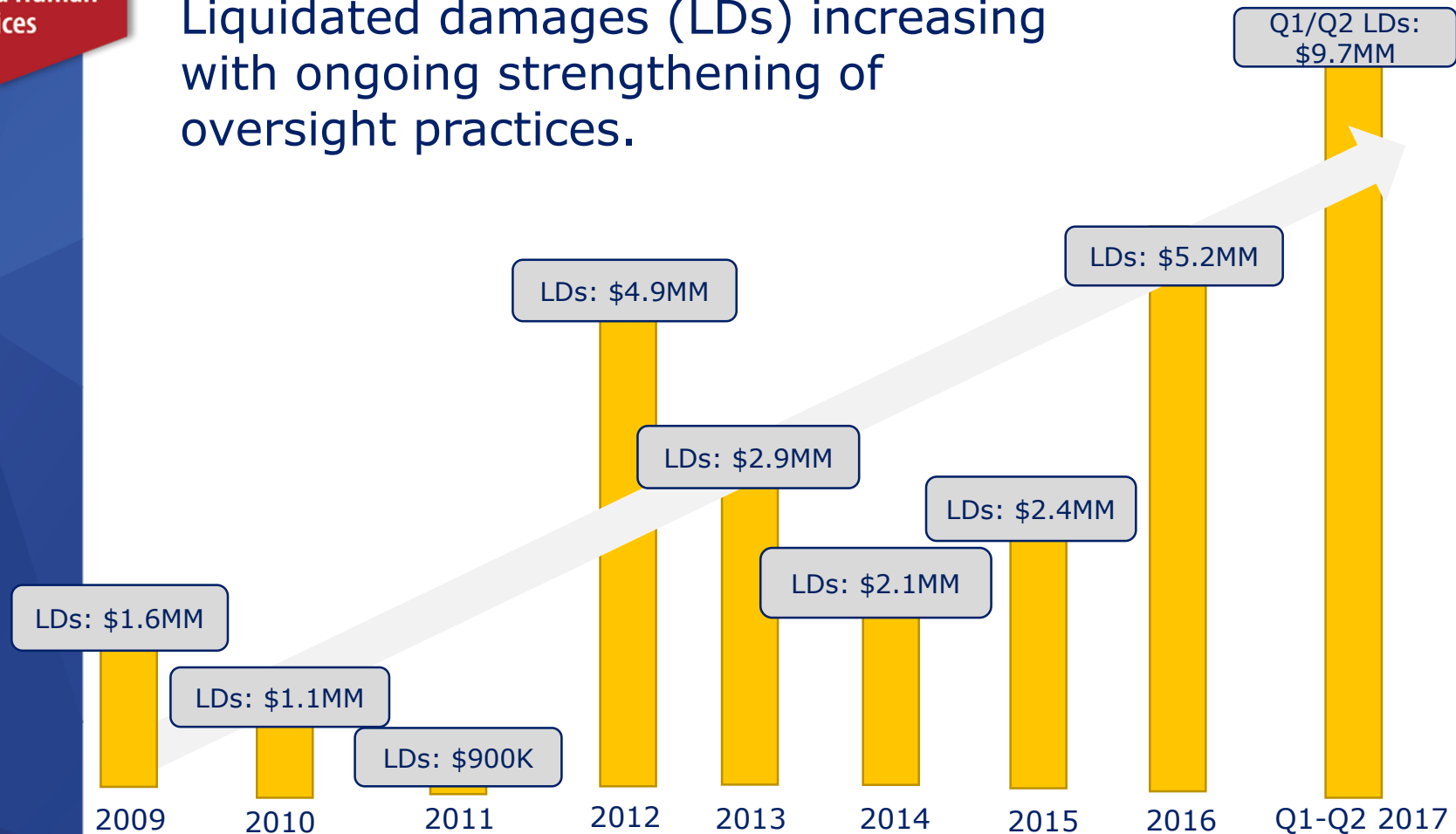


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Financial impact stage

Liquidated damages issued

Liquidated damages (LDs) increasing with ongoing strengthening of oversight practices.





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MCO Oversight

Next steps and recommendations

Maximize current contract resources

Implement an Annual Review of MCO deliverables to identify deliverables that no longer contribute to evaluation of outcomes and performance.

Consider service delivery area reconfiguration for future procurements

Engage stakeholders in development of potential new configurations.

Utilization review expansion

Seek resources to expand STAR+PLUS utilization reviews and include reviews for STAR Health and STAR Kids programs.